## **Dental Claim Form** Check One: △ DELTA DENTAL® P.O. Box 43026 □ Dentist's pre-treatment estimate Phoenix, AZ 85080-3026 □ Dentist's statement of actual services Delta Dental Plan of Arizona Patient name 2. Relationship to Member/Insured 4. Patient Birthdate 5. If full-time student, attach verification 3. Sex ☐ self ☐ child school М F MM DD ☐ spouse ☐ other city Ņ 6. Member/Insured name Member/Insured social 8. Member/Insured birthdate 9. Group Policyholder (company) 10. Group number and mailing address security or I.D. number name and address MM DD 12-a. Name and address of Insurance carrier(s) 11. Is patient covered by another 12-b. Group no.(s) 13. Name and address of other Policyholder(s) ves If yes, complete sections 12-15 Is patient covered by a medical plan? yes 14-a. Member/Insured name 14-b. Member/Insured social 14-c. Member/Insured birthdate 15. Relationship to patient (if different than patient's) security or I.D. number MM DD YYYY? self parent Ö N spouse other I hereby accept the stated treatment plan and authorize release of any information relating to this claim. I understand that the portion of the dentist's charges covered under the dental care plan named above will be paid direct to the dentist unless the dentist is not participating with a Delta Plan and I am personally responsible for any portion of those charges not covered by the Plan. Signature (Patient or Parent if Minor) X \_\_\_ Date 16. Name of Billing Dentist or Dental Entity 24. Is treatment result No Yes If yes, enter brief description and dates of occupational illness or injury? 17. Address 25. Is treatment result of auto accident? City, State, Zip 26. Other accident? G 18. Dentist Soc. Sec. or T.I.N. 19. Dentist license no. 20. Dentist phone no. 27. If prosthesis, is this (If no, reason for replacement) 28. Date of prior initial placement? placement 22. Place of treatment Office | Hosp. | ECF 21. First visit date 23. Radiographs or No Yes How 29. is treatment for If services already Mos. treatment Date appliances Other models enclosed? current series many? orthodontics? commenced placed remaining enter: 30. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Use charting system shown. For IDENTIFY MISSING TEETH WITH "X" Date service Procedure administrative Description of Service Fee Surface (including x-rays, prophylaxis, materials used, etc.) performed number **FACIAL** use only Day Year 31. Narrative for unusual services I hereby certify that the procedures as indicated by date of service performed have been performed according to the provisions of the dental care plan Total Fee named above. Also, that the fees submitted are the actual fees I have charged and intend to collect for these procedures. Payment for said procedures Charged Dentist Signature X Date \_ Max. Allowable FOR CLAIMS AND BENEFIT INFORMATION, CONTACT: Deductible DAISY (Delta's Automated Information System) CUSTOMER SERVICE: Carrier % (602) 938-3131, ext. 1 (800) 352-6132, ext. 1 (602) 938-3131, ext. 2 (800) 352-6132, ext. 2

© American Dental Association, 1990

Rev. 9/97

Carrier pays

Patient pays